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## Blue Choice

### [100/80, 90/70, 80/60, 70/50]%

### Groups of [Less Than 51 Employees]

This is a Schedule of Benefits to your Blue Choice plan. It is attached to and becomes part of your Anthem Blue Cross and Blue Shield Blue Choice Certificate of Coverage (030171). Please refer to your Certificate of Coverage which provides detailed information about your Plan.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción. (Translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your id card or in your enrollment booklet.)

Group Name: ~	Group Number: ~	Effective Date: ~
<b>Cost Shares</b>		
<b>Calendar Year Deductibles:</b> General Deductible  [Individual Deductible] [Family Deductible]  Prescription Drugs	[\$250 to 5,000] Individual Deductible [\$500 to 10,000] Family Deductible <b>OR</b> [Network] [Non-Network] [\$0 to \$5,000][or] [\$7,500] [or] [\$10,000] [\$0 to \$10,000] [or] [\$15,000][or] \$20,000 [\$0 to \$10,000] [or] [\$15,000] [or] [\$20,000] [\$1,000 to \$20,000] [or] [\$30,000] [or] [\$40,000]  [\$0 to \$200]	
<b>Calendar Year Coinsurance Limit</b>  [Individual Coinsurance] [Family Coinsurance]	[\$1,000 to \$5,000] Individual Coinsurance Limit [\$2,000 to \$10,000] Family Coinsurance Limit <b>OR</b> [Network] [Non-Network] [\$0 to \$5,000] [or] [\$7,500] [or] [\$10,000] [\$2,000 to \$10,000] [or] [\$15,000] [or] [\$20,000] [\$0 to \$10,000][or] [\$15,000] [or] [\$20,000] [\$4,000 to \$20,000] [or] [\$30,000] [or] [\$40,000]	
<b>Total Out-of-Pocket Limit</b>  [Individual Out of Pocket] [Family Out of Pocket]	[\$1,250 to \$10,000] Individual [\$2,500 to \$20,000] Family <b>OR</b> [Network] [Non-Network] \$[0 to 10,000][12,500] [or] [15,000] [or] [20,000] \$[2,500 to 20,000][25,000] [30,000] [or] [40,000] [0 to 20,000] [25,000][or] [30,000] [or] [40,000] [5,000 to 40,000][50,000][60,000][or][80,000]	
<b>Lifetime Maximum Benefits:</b>	[Unlimited]	

\*Services for Autism, Home Health Care and Hospice are not applied to the Physical Therapy/Occupational Therapy, Speech Therapy or Skilled Nursing/Inpatient Rehabilitation limits.

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Each visit to a professional or facility may include multiple types of services listed in this document. Benefits will be provided based upon which service codes are billed by the provider, and each type of service may be subject to different and/or multiple limits and/or cost shares.

Service	Network Benefit	Non-Network Benefit
<b>Hospital Services</b> Inpatient (Prior authorization required for non-emergency inpatient admissions)  Outpatient  Emergency Room Services – If you are admitted to the hospital from the emergency room, the copayment (if applicable) is waived.	[100, 90, 80, 70%] after deductible  [100, 90, 80, 70%] after deductible  [ [100, 90, 80, 70%] after deductible] Or [100% after a [\$100 or \$150] Copayment]	[80, 70, 60, 50%] after deductible  [80, 70, 60, 50%] after deductible  [[80, 70, 60, 50%] after deductible] Or [80% after a [\$100 or \$150] Copayment]
<b>High Tech Diagnostic Radiology</b> (including but not limited to CT Scans, MRI/MRAs, Nuclear Cardiology, PET Scans.) These services require prior authorization.	[100, 90, 80, 70%] [after deductible]	[80, 70, 60, 50%] [after deductible]
<b>Professional Services</b> Inpatient and Outpatient Diagnostic tests Surgery	[100, 90, 80, 70%] after deductible [100, 90, 80, 70%] [after deductible] [100, 90, 80, 70%] [after deductible]	[80, 70, 60, 50%] after deductible [80, 70, 60, 50%] [after deductible] [80, 70, 60, 50%] [after deductible]
<b>Physician Office Visits</b> Primary Care Services;  Routine/Preventive  Specialist Services; Walk-In Center/Retail Health Clinic.	100% after [\$10, \$20, \$25 or \$30 ] copayment 100% after [\$0, \$10, \$20, \$25 or \$30 ] copayment 100% after [\$0 to \$50] copayment 100% after [\$0 to \$50] copayment Copayment applies to office visit charge only Plan level (see Professional Services) applies to related covered services	80% after [\$10, \$20, \$25 or \$30] copayment 80% after [\$0, \$10, \$20, \$25 or \$30] copayment 80% after [\$0 to \$50] copayment 80% after [\$0 to \$50] copayment
<b>Miscellaneous</b> Occupational, and Physical Therapies – Combined limit of 20 visits per calendar year  Speech Therapy – Limited to 20 visits per calendar year  Chiropractic Care / Manipulative Therapy - Combined limit of 40 visits per calendar year  Skilled Nursing Facility & Inpatient Rehabilitation – [Combined limit of 150 days per calendar year]  *Home Health Care  *Hospice  [Mammography (preventive & diagnostic)]  [Colonoscopy (preventive & diagnostic)]	[100, 90, 80, 70%] after deductible  [100, 90, 80, 70%] after deductible  [100, 90, 80, 70%] after deductible Or [100% after applicable Physician or Specialist copayment]  [100, 90, 80, 70%] after deductible  [100, 90, 80, 70%] after deductible  [100%]  [100% deductible does not apply]  [100% deductible does not apply]	[80, 70, 60, 50%] after deductible  [80, 70, 60, 50%] after deductible  [80, 70, 60, 50%] after deductible Or [80% after applicable Physician or Specialist copayment ]  [80, 70, 60, 50%] after deductible  [80, 70, 60, 50%] after deductible  [80% deductible does not apply]  [80% deductible does not apply]  [80% deductible does not apply]

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Early Intervention Services – Limited to \$3,200 per year per child for children up to 36 months of age	[100, 90, 80, 70%] after deductible	[80, 70, 60, 50%] after deductible
*Autism Spectrum Disorders – Applied Behavior Analysis is limited to children 10 years of age or under.	[100, 90, 80, 70%] after deductible	[80, 70, 60, 50%] after deductible

<b>Smoking Cessation</b> Smoking Cessation Program [– up to \$35 per program / \$70 per lifetime]	[100, 90, 80, 70%] [after deductible]	[80, 70, 60, 50%] [after deductible]
Physician Office Visits [– up to 2 per calendar year]	[100% after Physician Office Visit copayment] or [100%]	[80% after Physician Office Visit copayment] or [80%]
Smoking Cessation Medications [– Up to \$200 per calendar year / \$400 per lifetime]	See Prescription drug section	See Prescription drug section
Durable Medical Equipment & Prostheses (excluding limbs)	[100, 90, 80, 70%] after deductible	[80, 70, 60, 50%] after deductible
Prostheses for limb replacement	[100, 90, 80%]	80% (deductible does not apply)

<b>Mental Health and Substance Abuse Services</b>		
Mental health and substance abuse services are managed by Anthem Behavioral Health and all services require preauthorization. Failure to comply with the requirements outlined in your certificate of coverage may result in a penalty up to \$300.		
<b>Service</b>	<b>Network Benefit</b>	<b>Non-Network Benefit</b>
Inpatient	[100, 90, 80, 70%] after deductible	[80, 70, 60, 50%] after deductible
Day treatment	[100, 90, 80, 70%] after deductible	[80, 70, 60, 50%] after deductible
Outpatient	[100, 90, 80, 70%] after deductible	[80, 70, 60, 50%] after deductible
Office visits	[100% after Physician Office Visit copayment] Or [100, 90, 80, 70%, no deductible]	[80% after Physician Office Visit copayment] Or [80, 70, 60, 50%, no deductible]

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